



Menuflex™ MDSA Application Kit

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HOW TO APPLY:

Self-employed Individuals:

1. Provide the General Information and Dependent Information as requested in Sections 1 & 2.
2. In Section 3, indicate your chosen level of coverage (Single, Couple, Family with ____ Child/Children)
3. In Section 4, determine the amount of your monthly contribution based on the net annual amount that you wish to have in your MDSA. Tick the appropriate box, and copy the Monthly Cost amount below it to Box (1) Monthly Contribution.
4. Sign and Date the Application.
5. Finally, complete the MDSA Administrative Services Agreement, and **attach a VOID cheque** to enable Alternative Benefits Solutions Inc. (ABS) to collect the MDSA contributions and any Optional Benefit premiums on the first Thursday of every month.

Send the completed documents to:

Alternative Benefit Solutions Inc.
5045 Orbitor Drive, Unit 10
Suite 300
Mississauga, Ontario L4W 4Y4

Alternative Benefit Solutions Inc. (ABS) will confirm acceptance for coverage as quickly as possible and will issue a Program Booklet and MDSA claim forms.

If you have questions or need assistance in completing the forms, please contact us at toll-free: 1-866-636-8359

Section 1: General Information

YOUR NAME LAST NAME FIRST NAME INITIAL			MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> OTHER _____		
DATE OF BIRTH (DD/MM/YYYY)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH	PRIMARY OCCUPATION		
HOME ADDRESS		CITY	PROVINCE	POSTAL CODE	
HOME TELEPHONE	WORKPLACE TELEPHONE		FAX		
EMAIL ADDRESS		YOUR EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> CONTRACTOR <input type="checkbox"/> INCORPORATED			
YOUR COMPANY NAME	YOUR BUSINESS ADDRESS	CITY	PROVINCE	POSTAL CODE	
YOUR AGENT / BROKER'S NAME (IF APPLICABLE)		AGENT / BROKER'S TELEPHONE:	AGENT / BROKER'S E-MAIL ADDRESS:		
AGENT / BROKER'S ADDRESS:		CITY	PROVINCE	POSTAL CODE	

Section 2: Dependent Information

Last Name	First Name & Initial	Sex (M/F)	Birthdate (DD/MM/YYYY)	If Child Over 21
Spouse:				
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED

If a Child is over age 21, state if a Student or Disabled. Students must provide proof of attendance at school (ie. a copy of their student card).

Section 3: Please indicate your level of coverage: Single Couple Family with _____ Child / Children

Section 4: Individual MDSA Contribution Amount (Monthly Premium Rate Calculation)

Net Annual Amount Desired in MDSA	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> Other _____
Monthly Cost*	\$52.09	\$104.16	\$156.25	\$208.34	\$520.84	

Indicate the Net Annual Amount Desired in your MDSA, and calculate the Monthly Contribution Amount for the box at right. Divide the net amount required in the MDSA account by .80 and then divide by 12 to determine the monthly payment including administration costs, e.g. if someone requires a net amount of \$3,600 the monthly contribution required would be \$375.00 (\$3,600 ÷ .80 = \$4,500 ÷ 12 = \$375 per month)

* Includes all administration fees and applicable taxes

Monthly Contribution*	\$ _____ (1)
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Section 5: Declaration & Authorization

I acknowledge that Personal Information collected with this Application for Insurance is confidential and will not be used for any purpose other than in conjunction with this request for, and subsequent administration of, the health insurance protection that is afforded to Applicants, Spouses, and Dependent Children under this plan.

I understand that coverage commences only after the Plan Administrator confirms our acceptance in writing.

I authorize the Plan Administrator, Alternative Benefit Solutions Inc., to withdraw from my financial institution the required insurance premiums, and acknowledge that the amount may vary as my required premium is increased or decreased under this program at the Policy Anniversary date of August 1st each year.

Signed at: _____ this _____ day of _____, _____ Applicant's Signature _____
CITY / TOWN PROVINCE DATE MONTH YEAR

Section 6: Privacy & Confidentiality

We protect our customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of detail shared about any plan member and his or her dependents' benefits. In terms of telephone inquiries to Alternative Benefit Solutions Customer Service, the information provided varies based on the relationship of the person making the inquiry to the insured (e. g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only information pertaining to the specific claim or treatment in question is shared.

- Notes:**
- Coverage commences only after the Plan Administrator confirms your acceptance in writing.**
 - Please remember to attach a cheque marked "VOID" to enable monthly premium payments.**

Mail or Fax your completed application to:
Alternative Benefit Solutions Inc.
 5045 Orbitor Drive, Unit 10
 Suite 300
 Mississauga, Ontario L4W 4Y4



Phone: (905) 629-1252
 Toll-free: 1-866-636-8359
 Fax: (905) 602-7983
 E-mail: apps@alternativebenefits.ca

To be completed by the Employer or Incorporated Self-Employed Individual. Employees do not need to complete this document.

MEDICAL & DENTAL SPENDING ACCOUNT ADMINISTRATIVE SERVICES AGREEMENT

Between

Alternative Benefit Solutions Inc.

(Owner of the **Menuflex**TM Trademark & Third Party Administrator of the Program)

And

Employer:

Address:

OBJECTIVE: The objective of this **Medical & Dental Spending Account** is to assist participants with the funding of their medical and dental expenses on a non-insured basis.

WHEREAS:

1. The sponsoring employer wishes to establish a **Medical & Dental Spending Account**, otherwise known as a **Health Spending Account**, which qualifies as a “private health services plan”, as defined in IT Bulletin IT339R2 of the *Income Tax Act*, for its employees and their dependents;
2. The eligible medical expenses to be reimbursed under the MDSA are as defined in Section 118.2 (2) of the *Income Tax Act*, and *Interpretation Bulletin IT-519R2*;
3. **Alternative Benefit Solutions Inc.** is engaged in the administration of employee benefit/insurance programs under the **Menuflex**TM banner;

NOW THEREFORE:

Alternative Benefit Solutions Inc. (ABS) as the **Third Party Administrator** and the **Employer** hereby agree as follows:

- (1.) **ABS** will act as the **Administrator** of the **MDSA** on behalf of the **Employer**;
- (2.) **ABS’s responsibilities will include, but will not necessarily be limited to the following:**
 - (a) Receipt and deposit of the monthly/annual employer contributions to the **MDSA** in a Trust Account at one of Canada’s principal Banks.
 - (b) Establishment of individual employee accounts indicating the balance in their **MDSA** Account.
 - (c) Confirming and paying the **MDSA** claims that meet the definition of eligible Medical & Dental expenses as defined in subsection 118.2(2) of the *Income Tax Act* and *IT-519R2*.
 - (d) On each claim payment indicate the balance in the employee’s account.
 - (e) Holding on file any **MDSA** claim where there are insufficient funds in the employee’s account until further employer contributions have been received.
 - (f) At year-end, advising the employer of the carry forward amounts in the employee accounts.
 - (g) Refunding carry forward amounts to the employer, which have been forfeited by employees, at the appropriate time following the end of a Plan Year.
 - (h) Notification of eligible participants and payment of the monthly premiums with respect to the **Optional Supplementary EHC or EHC + Dental plans**, or other **Optional Benefits** to the appropriate insurer(s) and service providers.
 - (i) Issuing employee booklets describing the **MDSA Program** and the method of filing claims; responding to employee inquiries regarding the Program.
- (3.) **The Employer will be responsible for:**
 - (a) Enrolling newly eligible employees and remitting the forms to ABS to enable them to be added to their database.
 - (b) Distributing the **Menuflex**TM MDSA Program Booklets and claim forms produced by ABS to all employees enrolled in the Program.
 - (c) Reporting additions or terminations of employees, or changes in their status under the Program (e.g. a single employee becoming married, or an employee adding dependents).
 - (d) Ensuring that there are sufficient funds in the corporate bank account on the first Thursday of every month to allow ABS to withdraw the monthly contributions to the **MDSA** including Administration fees, any insurance premiums, as well as any **Optional Benefit** premiums that are being paid for by employees through payroll deductions.

- (e) Notifying ABS at least 30 days prior to the end of each Plan Year of any changes to the Employer contribution amounts for the following Plan Year.

Other Terms and Conditions:

1. The **Employer** authorizes **ABS** to make payments from each eligible employee's account in settlement of eligible **MDSA** claims.
2. **MDSA** funds held by **ABS** will bear no interest for the employer.
3. **ABS** will not be liable for any **MDSA** claims paid where the employee failed to provide accurate information as to the eligibility of the claim or a dependent for coverage under the Program.
4. Either party, upon thirty (30) days written notice, can terminate this Agreement. In the event of termination **ABS** will provide a terminal accounting of all employer contributions received and **MDSA** claims paid within 90 days of termination of the Program, as employees have up to 30 days to submit any outstanding claims incurred prior to the date of termination.
5. The **Employer** shall be required to fund its obligations under this Agreement, including Administration fees, up to and including the date of termination.
6. This **Master Application and Agreement**, and **MDSA Application/Enrolment Forms**, constitutes the entire Agreement. No Agent, Broker, or other person has authority to waive any conditions of this Agreement; to modify the Agreement, or to bind **ABS** by making any promise or representation or by giving or receiving any information.

As a participating employer we wish to make the following monthly MDSA contributions:

Class A: _____ \$ _____/month
(Define eligible class)

Class B: _____ \$ _____/month

Class C: _____ \$ _____/month
(Note: All employees may be in one class)

We wish to cover a total of _____ employees under the MDSA effective: _____

A **Deposit Employer Contribution** in the amount of \$ _____ (payable to **Alternative Benefit Solutions Trust**) is attached along with a **VOID cheque** for future payments.

The terms of this Application and Agreement are hereby accepted by:

_____ Dated at: _____ on _____
(Employer)

_____ Title: _____
(Authorized representative)

(Witness)

Broker: _____

Address: _____ Tel: _____ Fax: _____

E-Mail: _____

Please mail, FAX or courier to: **Alternative Benefit Solutions Inc.**
5045 Orbitor Drive, Unit 10, Suite 300
Mississauga, Ontario L4W 4Y4 Fax: 905-602-7983